Wisconsin Medicaid School Based Services Certification Packet

Wisconsin
Department of
Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Dear Medicaid Provider Applicant:

Thank you for applying for certification with the Wisconsin Medicaid program. Once you are a Medicaid provider, you will play a significant part in improving the health of low-income people in your community.

Enclosed are the certification materials you requested. Please review these materials carefully. These materials must be completed and processed before you may become a certified provider for the Wisconsin Medicaid program and begin receiving payments.

Upon certification as a Wisconsin Medicaid provider, you will receive the All Provider Handbook containing general instructions for all providers. In addition, you will also receive publications relating to the specific services you will be providing. These publications will identify the services covered by the Medicaid program and will describe Medicaid billing procedures. After reading those materials, if you have additional questions, we encourage you to use provider services. These services include both telephone and on-site assistance. If you are interested in using these services, please contact the Provider Services Unit addresses and telephone numbers listed in the All Provider Handbook.

We realize that all providers appreciate prompt payments, so we encourage providers with computers to submit claims electronically. This method reduces clerical errors and decreases turn around time. If you are interested in electronic submission of claims and would like more information, including the free software, please contact (608) 221-4746. Information is included in your certification materials regarding electronic submission of claims.

Thank you, again, for your interest in becoming a certified Wisconsin Medicaid provider and for the important services that you will provide to Medicaid recipients. If you have any questions about enclosed materials, please contact the Wisconsin Medicaid Correspondence Unit at (608) 221-9883 or toll-free at 1-800-947-9627.

Sincerely,

Peggy B. Handrich

Peggy B. Handrich
Associate Administrator

PBH:mhy
MA11065.KZ/PERM

Enclosure

Wisconsin Medicaid
Checklist for Certification

The items listed below are included in your certification application. Please use this form to check that you received the materials and verify which materials you returned. Please copy all documents for your records before sending them to the fiscal agent. Keep this checklist for your records. Mail your completed application to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

The required items must be completed and returned to EDS:

	Item	Required	Optional	Date Sent
1.	Provider Application	X		
2.	Provider Agreement (2 copies)	X		
3.	Chart A (for CESAs only) Chart B Chart C Chart D	X		
4.	Request for a Waiver		X	
5.	School Based Services Activity Log		X	

These items are included for your information. Do not return them:

	Item
1.	General Information
2.	Certification Requirements
3.	Terms of Reimbursement
4.	School Based Services Benefits
5.	Electronic Billing Information

Wisconsin Medicaid Program
General Certification Information

Enclosed is the certification application you requested to be a Wisconsin Medicaid provider. Your certification for Wisconsin Medicaid can be approved when you send a **correctly completed application** to the address below and meet all certification requirements for your provider type. **Wisconsin Medicaid cannot reimburse any services you provide prior to your approved certification effective date.** Please carefully read the attached materials.

Where to Reach Us

If you have questions about the certification process, please call the Wisconsin Medicaid Correspondence Unit for Policy/Billing Information at (608) 221-9883 or toll-free at 1-800-947-9627.

Copy all application documents for your records. Send your completed certification materials to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Certification Effective Date

Wisconsin Medicaid regulations are followed when assigning your initial effective date as described here:

1. The date you notify Wisconsin Medicaid of your intent to provide services is the earliest effective date possible and will be your initial effective date **if**:
   - You meet all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Medicaid on the date of notification. Do not hold your application for pending licensure, Medicare, or other required certification. Wisconsin Medicaid will keep your original application on file. Send Wisconsin Medicaid proof of eligibility documents immediately once available for continued processing.
   - Wisconsin Medicaid receives your **properly completed certification** application within 30 days of the date the application was mailed to you.

2. If Wisconsin Medicaid receives your application more than 30 days after it was mailed to you, your initial effective date will be the date Wisconsin Medicaid receives your correctly completed application.

3. If Wisconsin Medicaid receives your incomplete or unclear application within the 30-day deadline, you will be granted one 30-day extension. Wisconsin Medicaid must receive your response to Wisconsin Medicaid's request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension may allow you additional time to obtain proof of eligibility (such as license verifications, transcripts, other certification, etc.)

4. If you don't send complete information within the original 30-day deadline or 30-day extension, your initial effective date will be based on the date Wisconsin Medicaid receives your complete and accurate application materials.

Notification of Certification Decision

Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your certification. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process.

If you are certified to provide Medicaid services, you will receive written notice of your approval, including your Wisconsin Medicaid provider number and certification effective date.

Notification of Changes

Your certification in Wisconsin Medicaid is maintained only if your certification information on file at Wisconsin Medicaid is current. You must inform Wisconsin Medicaid in advance of any changes such as licensure, certification, group affiliation, corporate name, ownership, and physical or payee address. **Send your written notice to Wisconsin Medicaid Provider Maintenance**. This notice must state when these changes take effect. Include your provider number(s) and signature. Do not write your notice or change on claims or prior authorization requests.

Failure to notify Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event provider mail is returned to Wisconsin Medicaid for lack of current address.

Provider Agreement Form

Your agreement to provide Medicaid services must be signed by you and the Wisconsin Department of Health and Family Services. This agreement states that both parties agree to abide by Wisconsin Medicaid's rules and regulations.

The agreement is valid for a maximum of one year. All Provider Agreements expire annually on March 31. The Department of Health and Family Services may renew or extend the Provider Agreement at that time.

You cannot transfer, assign, or change the Provider Agreement.

The application includes two copies of the Provider Agreement. Complete, sign, and return both copies. Type or clearly print your name as the applicant's name both on the line on page 1 and on the appropriate line on the last page of the agreement. You must use the same provider name on the application forms and Provider Agreement. When the certification process is complete, you will receive one copy of your processed and signed Provider Agreement. The other copy will be kept in your Wisconsin Medicaid file.

Terms of Reimbursement (TOR)

The TOR explains current reimbursement methodologies applicable to your particular provider type. It is referenced by, and incorporated within, the provider agreement. Keep the TOR for your files.

Certification Requirements

The Wisconsin Administrative Code contains requirements that providers must meet in order to be certified for Wisconsin Medicaid. The code and any special certification materials applicable to your provider type are included as certification requirements.

Publications

Along with your notice, Wisconsin Medicaid will send one copy of all applicable provider publications. The publications include program policies, procedures, and resources you can contact if you have questions.

Many clinics and groups have requested to receive only a few copies of each publication, rather than a personal copy for each Medicaid-certified individual provider in the clinic or group. If you are an individual provider who is a member of a Medicaid-certified clinic or group, you may reassign your copy to your clinic or group office. Please decide if you wish to receive your personal copy of Medicaid publications or if it is sufficient for your Medicaid-certified clinic or group office to receive copies.

If you do not wish to receive personal copies of Medicaid publications, please complete the attached "Deletion from Publications Mailing List Form." If you wish to have your copy of publications reassigned to your clinic or group, also complete the "Additional Publications Request Form."

SCHOOL BASED SERVICES CERTIFICATION CRITERIA

Requirements for Certification as a School Based Services (SBS) Provider:

A SBS provider shall be certified under the authority of sec. 49.45 (39), Wis. Stats.

SBS providers need to meet the medical and financial recordkeeping and documentation requirements under HFS 106, Wis. Adm. Code.

Staff qualification requirements:

- Documentation of staff qualifications per Wisconsin Administrative Code certification rules for the Department of Public Instruction (Ch. **PI** 3, Licenses), except nursing staff who must be licensed as a registered nurse pursuant to s. 441.06, or licensed as a practical nurse pursuant to s. 441.10, Stats.

Service-Related Requirements - The following records must be kept on file for 5 years after SBS services are billed:

- Documentation that services are included in the recipient's Individual Education Plan (IEP).
- Documentation that the service is prescribed or referred by a physician, or by a nurse practitioner with prescribing authority or by a licensed Ph.D. psychologist, as required under the benefit.
- Documentation that the services are medically necessary and the care plan contains measurable, outcome-oriented treatment goals and objectives.
- The required minimum clinical and other records required by SBS providers.

Audit Requirements - Providers shall maintain the following audit documentation for 5 years:

An annual audit documenting:

- Sufficient non-federal funds in the school district's, Cooperative Educational Service Agency's (CESA), or County Children with Disabilities Education Board (CCDEB) budget to constitute the required local match to the Federal Financial Participation (FFP) Funds. Matching funds are approximately 40% of the Medicaid reimbursement rate for services. Further instructions on how to calculate the required local match will be made available to certified providers.
- The billed services are provided and required records are maintained documenting delivery of the service.

Provider Type: 56 **Effective Date: July 1, 1995**

SCHOOL BASED SERVICES CERTIFICATION CRITERIA

Communication Requirements -- Providers shall maintain the following communication documentation:

SBS providers must document the required communication with non-school Medicaid providers, specifically:

- Sign joint Memorandums of Understanding (MOUs) with Medicaid certified HMOs serving their areas after July 1996. MOUs are legal documents that set policies and procedures to help coordinate care and avoid duplication of services.

- When a child receives services from a Wisconsin Medicaid fee-for-service provider in addition to an SBS provider, the SBS provider must:

    - Document regular contacts with fee-for-service providers, at least annually, as appropriate for each child.

    - Cooperate with Wisconsin Medicaid fee-for-service providers who request copies of the child's IEP, IFSP, or components of the multidisciplinary team (M-Team) evaluation.

Other Requirements for SBS Providers:

Duplicate CESA and School District Certification

School districts may be certified as SBS providers under two different arrangements:

- Independently as a school district, or

- Under the umbrella certification of a CESA.

A school district may not be certified both independently as a school district and under the umbrella of a CESA. If a duplicate certification application is received, Wisconsin Medicaid will cancel the original certification after contacting the SBS applicant and before issuing the new SBS provider number.

CESAs applying for certification must complete Chart A (attached) to list school districts included under the umbrella of the SBS certification. CESAs must revise and resubmit Chart A whenever the list of school districts included under the CESA's SBS certification changes.

SCHOOL BASED SERVICES CERTIFICATION CRITERIA

Duplicate Provider Types

Wisconsin State Statutes s. 49.45(39) requires that school districts, CESAs and CCDEBs delivering services covered under the SBS benefit must bill under the SBS certification.

The following Medicaid provider certification types duplicate SBS certification:

- Physical Therapy (PT) Group and Individual PTs and PT Assistants
- Occupational Therapy (OT) Group and Individual OTs and OT Assistants
- Speech and Hearing Clinic
- Audiology Group and Audiologists
- Therapy Group
- Speech Pathology/Therapy Group and Speech Pathologists
- Rehabilitation Agency
- Transportation
- Nurse Practitioner Group and Nurse Practitioners
- Nurse Group and Individual Nurses

1. Duplicate Group/Clinic/Agency Medicaid Provider Certification

   Schools, school districts, CESAs or CCDEBs with group/clinic/agency Medicaid provider certification in the above duplicate areas must be reported on Chart B (attached). These certification provider numbers will be ended.

2. Duplicate Individual Medicaid Provider Certification

   Individuals with Medicaid provider certification in the above duplicate areas where a school, school district, CESA or CCDEB is the individual's payee* must reassign their payee or the duplicate Medicaid certification will be ended. The date used will be one day before the effective date of the school district's, CESA's or CCDEB's SBS certification, the date specified in Wisconsin Medicaid, notice to the certified individual, or whichever is later. The new payee selected by the certified individual cannot be a school, school district, CESA or CCDEB, bu ma be the certified individual or another entity.

   Medicaid-certified individuals in the above duplicate areas where a school, school district, CESA or CCDEB is the payee must be reported on Chart C (attached).

   To reassign their payee, the individually certified provider must complete and return a Wisconsin Medicaid Provider Change of Address or Status Form (from the Wisconsin Medicaid All Provider Handbook).

   * The school, school district, CESA or CCDEB is the individual's payee when the Medicaid payment is made to the school, school district, CESA or CCDEB, and the Medicaid income is reported to the Tax I.D. number which belongs to the school, school district, CESA or CCDEB.

SCHOOL BASED SERVICES CERTIFICATION CRITERIA

If Wisconsin Medicaid does not receive the completed Wisconsin Medicaid Provider change of address or status Form(s) with the school district's, CESA's or CCDEB's SBS application, each individual with duplicate certification will be sent a letter notifying them of the date by which the completed form must be returned to Wisconsin Medicaid. If the completed form is not returned by the date specified in the letter, the individual's Medicaid certification provider number will be ended as described on Page 3.

Future Certification of Duplicate Providers

Medicaid will not approve future group/clinic/agency provider certification for the duplicate provider types listed on Page 3 for schools, school districts, CESAs or CCDEBs. Individual certification for these duplicate provider types, where the school, school district, CESA or CCDEB is the payee, will also not be approved.

Non-Duplicate Provider Types

Medicaid will not end current Medicaid certification that does not duplicate services covered under the SBS benefit, such as Medicaid certification for HealthCheck or Prenatal Care Coordination. However, please identify all current Medicaid non-duplicate provider certification numbers on Chart D (attached) held by the schools, school districts, CESA or CCDEB included in this SBS application, as well as their staff.

Effective Date of Certification as a SBS Provider

School districts, CESAs or CCDEBs returning a complete SBS application received at Wisconsin Medicaid will be certified according to certification regulations explained in the cover letter to this certification application.

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
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SCHOOL BASED SERVICES
TERMS OF REIMBURSEMENT

The Department shall reimburse the school district or cooperative educational service agency for sixty-percent of the federal share of allowable charges for the school medical services that it provides, and for allowable administrative costs, or as otherwise determined by the State Legislature.

The Department will establish statewide contract rates for all covered services provided by certified school based services providers to Wisconsin Medicaid recipients eligible on the date of service. The statewide rates shall be based on various factors, including a review of costs and utilization data for school districts, surveys of a cross-section of school districts, rates for private providers of similar services, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Rates may be adjusted to reflect reimbursement limits or limits on the availability of federal funding.

Providers are required to bill the rate established by Medicaid for services provided.

The Medicaid program receives federal funding which must be matched by state or local government funds. Under Wisconsin Statutes Section 49.45(39), any participating school based services provider is required to provide this local match. Expenditures for providing services to Medicaid-eligible recipients can serve as the local match provided they are funded by state aid and local taxes.

School districts and CESAs are required to certify that they have made sufficient local expenditures which qualify as the local match for federal funding. Documentation of certified matching funds must be maintained by the school district or CESA.

The Department will adjust payments to providers to reflect the amounts of any allowable recipient copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes. Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting statewide rates for services.

Applicable Provider Type(s): 56

Effective: July 1, 1995

WISCONSIN MEDICAID

PROVIDER APPLICATION INFORMATION AND INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. However, in order to be certified, you must complete this form and submit it to the address indicated.

INSTRUCTIONS: Type or print your information on this application. Complete all sections. If a question does not apply to your application, write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

IMPORTANT NOTICE: In receiving this application from and granting Medicaid certification to the individual or other entity named below as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:

1. Provider Applicant submitted this application or authorized or otherwise caused it to be submitted.
2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted Provider Applicant will timely notify Wisconsin Medicaid of any such change.
3. By submitting this application or causing or authorizing it to be submitted, Provider Applicant agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.
4. Provider Applicant knows and understands the certification requirements included in the application materials for the applicable provider types.

If any of the foregoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's certification or take other action authorized under ch. HFS106, Wis. Admin. Code, or other legal authority governing Wisconsin Medicaid.

DISTRIBUTION — Submit completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison WI 53784-0006

If you have any questions, call Provider Services at (800) 947-9627.

FOR OFFICE USE ONLY

ECN	Date Requested	Date Mailed

Provider Number	Effective Date
Provider Type	**Provider Specialty**

WISCONSIN MEDICAID
PROVIDER APPLICATION

INSTRUCTIONS: Type or print clearly. Before completing this application, read Information and Instructions.

This application is for:

☐ Individual.
☐ Group/Clinic.
☐ Change of Ownership, effective __ __/__ __ /__ __ __ __.

SECTION I — PROVIDER NAME AND PHYSICAL ADDRESS

Special Instructions
Name — Provider Applicant — Enter only one name. All applicants (e.g., individuals, groups, agencies, companies) must enter their name on this line. If your agency uses a "doing business as" (DBA), then enter your DBA name. The name entered on this line must exactly match the provider name used on all other documents for Wisconsin Medicaid.

Name — Group or Contact Person — Individual applicants employed by a group or agency should indicate their employer on this line. Applicants who are not employed by a group or agency may use this line as an additional name line or attention line to ensure proper mail delivery.

Address — Physical Work — Indicate address where services are primarily provided. Wisconsin Medicaid will send general information and correspondence to this address. Official correspondence will be sent certified. Failure to sign for official correspondence could result in decertification. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address.

Date of Birth — Individual / Social Security Number — Required for individual applicants only. Enter date as MM/DD/YYYY.

Name — Medicaid Contact Person, Telephone Numbers, and Fax Number — List the name, telephone number, and fax number of a person within your organization who can be contacted about Medicaid questions. Also list a telephone number clients can use to reach you. This telephone number must be kept current with Wisconsin Medicaid.

Medicare Part A Number and Medicare Part B Number — Required for Medicare-certified providers. Please use Medicare numbers appropriate for the same type of services as this application.

Name — Provider Applicant (Agency Name or Last, First Name, Middle Initial)			
Name — Group or Contact Person			
Address — Physical Work			
City	State	Zip Code	County
Date of Birth — Individual	SSN		Name — Medicaid Contact Person
Telephone Number — Medicaid Contact Person	Telephone Number — For Client Use		Fax Number
Current and/or Previous State Medicaid Provider Number ☐ Wisconsin ☐ Other			
Medicare Part A Number			Effective Date
Medicare Part B Number			Effective Date

SECTION II — ADDITIONAL INFORMATION

Special Instructions
Respond to all applicable items:

- **All applicants must complete question 1. Providers with a physical address in Minnesota, Michigan, Iowa, or Illinois** must attach a copy of their current license.
- **Physicians** must answer **question 2**.
- **Applicants who will bill for laboratory tests** must answer **question 3**. Attach a copy of their current Clinical Laboratory Improvement Amendment (CLIA) certificate.
- **All applicants certified to prescribe drugs** must answer **question 4**.
- **Individuals affiliated with a Medicaid-certified group** must answer **question 5**.

1. Individual or Agency License, Certification, or Regulation Number(s)

2. Unique Physician Identification Number (UPIN)

3. CLIA Number

4. Drug Enforcement Administration (DEA) Number

5. Medicaid Clinic/Group Number

SECTION III — PROVIDER PAYEE NAME AND PAYEE ADDRESS

Special Instructions
Name — Payee — Enter the name to whom checks are payable. Individuals reporting income to the Internal Revenue Service (IRS) under a SSN must enter the individual name recorded with the IRS for the SSN. Applicants reporting income to the IRS under an employer identification number (EIN) must enter the name exactly as it is recorded with the IRS for the EIN.

TIN — Enter the Taxpayer Identification Number (TIN) that should be used to report income to the IRS. Check whether the TIN is an EIN or SSN. The number entered must be the TIN of the payee name entered. The payee name and TIN must exactly match what is on record with the IRS.

TIN Effective Date — This is the date the TIN became effective for the provider.

Name — Group or Contact Person (Optional) — Enter an additional name (e.g., business, group, agency) that should be printed on checks and Remittance and Status (R/S) Reports (payment/denial report) to ensure proper delivery.

Address — Payee — Indicate where checks and R/S Reports should be mailed. A post office box alone may be used for this address.

Name — Payee

TIN	TIN Effective Date	☐ EIN or ☐ SSN

Name — Group or Contact Person

Address — Payee

City	County	State	Zip Code

SECTION IV — TYPE OF CERTIFICATION

Check the provider type for this application from the list below. A separate application is required (in most cases) for each provider type for which you wish to be certified. An individual may choose only one provider type per application.

- ☐ Ambulance.
- ☐ Ambulatory Surgery Center.
- ☐ Anesthesiology Assistant*.
- ☐ Anesthetist CRNA.
- ☐ Audiologist.
- ☐ Audiologist/Hearing Instrument Specialist.
- ☐ Case Management.
- ☐ Chiropractor.
- ☐ Community Care Organization.
- ☐ Dentist, Specialty _____.
- ☐ End Stage Renal Disease.
- ☐ Family Planning Clinic.
- ☐ HealthCheck Screener.
- ☐ HealthCheck "Other" Services:
  - ☐ Other Eligible Services.
- ☐ Hearing Instrument Specialist.
- ☐ Home Health Agency:
  - ☐ With Personal Care.
  - ☐ With Respiratory Care.
- ☐ Hospice.
- ☐ Independent Lab.
- ☐ Individual Medical Supply:
  - ☐ Orthodontist and/or: Prosthetist.
    Other _____.
- ☐ Medical Vendor/Durable Medical Equipment (DME).
- ☐ Nurse Practitioner:
  - ☐ Certified Nurse Midwife (masters level or equivalent).
- ☐ Nurse Services (Independent Home Care):
  - ☐ Respiratory Care Services.
  - ☐ Private Duty.
  - ☐ Midwife.
- ☐ Occupational Therapy (OT).
- ☐ OT Assistant*.
- ☐ Optician.
- ☐ Optometrist.
- ☐ Osteopath (See below).
- ☐ Osteopath Group/Clinic (See below).
- ☐ Personal Care Agency.
- ☐ Pharmacy.
- ☐ Physical Therapy (PT).
- ☐ PT Assistant*.
- ☐ Physician (See below).
- ☐ Physician Assistant*.
- ☐ Physician Group/Clinic (See below).
- ☐ Podiatrist.
- ☐ Portable X-ray.
- ☐ Prenatal Care Coordination (PNCC).
- ☐ Rehabilitation Agency.
- ☐ Respiratory Therapist.
- ☐ Rural Health Clinic.
- ☐ School-Based Services.
- ☐ Specialized Medical Vehicle Transportation.
- ☐ Speech and Hearing Clinic.
- ☐ Speech and Pathology:
  - ☐ Master's Level.
  - ☐ Bachelor's Level*.
- ☐ Therapy Group (Two therapies, i.e., OT and PT).
- ☐ Others (Describe): _____
  _____.

*Individuals must be supervised and cannot independently bill Wisconsin Medicaid. In most cases, the clinic must submit claims.

Osteopaths or physicians, or a group/clinic of an osteopath or physician, must indicate the specialty below (select one specialty):

- ☐ Allergy.
- ☐ Anesthesiology.
- ☐ Cardiovascular Disease.
- ☐ Clinic.
- ☐ Dermatology.
- ☐ Ear, Nose, Throat Otorhinolaryngology.
- ☐ Emergency Medicine.
- ☐ Family Practice.
- ☐ Gastroenterology.
- ☐ General Practice.
- ☐ General Surgery.
- ☐ Geriatrics.
- ☐ Internal Medicine.
- ☐ Manipulative Therapy.
- ☐ Miscellaneous.
- ☐ Nephrology.
- ☐ Neurological Surgery.
- ☐ Neurology.
- ☐ Nuclear Medicine.
- ☐ Obstetrics and Gynecology.
- ☐ Oncology and Hematology.
- ☐ Ophthalmology.
- ☐ Optometry.
- ☐ Orthopedic Surgery.
- ☐ Pathology.
- ☐ Pediatrics.
- ☐ Pediatric Allergy.
- ☐ Pediatric Cardiology.
- ☐ Physical Medicine and Rehab.
- ☐ Plastic Surgery.
- ☐ Preventive Medicine.
- ☐ Proctology.
- ☐ Psychiatry (MDs attach a proof of completed psychiatric residency).
- ☐ Pulmonary Disease.
- ☐ Radiation Therapy.
- ☐ Radiology.
- ☐ Thoracic and Cardiovascular Surgery.
- ☐ Urgent Care.
- ☐ Urology.

SECTION V — MEMBERS OF GROUP OR CLINIC

Required: If this application is for a group or clinic, complete the chart below by listing all individuals providing Medicaid services at the clinic.

Name — Provider	Address — Provider Physical Work	Specialty	License Number	Provider Number

SECTION VI — APPLICANT'S TYPES OF SERVICE PROVIDED AND TYPE OF BUSINESS

1. List the types of Medicaid services the applicant's agency will provide (such as dental, emergency transportation, home health, personal care, pharmacy, physician, psychiatric counseling, respiratory care services, etc.).

2. Applicant's type of business (check appropriate box):

- ☐ Individual.
- ☐ Sole Proprietor:
  County and state where registered _____.
- ☐ Corporation for Nonprofit.
- ☐ Limited Liability.
- ☐ Corporation for Profit.
  State of registration _____

  Names of corporate officers _____

  _____
- ☐ Partnership.
  State of registration _____.

  Names of all partners and SSNs (use additional sheet if needed):

  Name _____ SSN _____

  Name _____ SSN _____

Governmental (check one):

- ☐ County.
- ☐ State.
- ☐ Municipality (city, town, village).
- ☐ Tribal.

- ☐ Other, specify _____.

Definitions for Sections VII-IX

Controlling interest — Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

SECTION VII — TERMINATION / CONVICTION / SANCTION INFORMATION

Has the applicant, any employee of the applicant, any person in whom the applicant has a controlling interest, or any person having a controlling interest in the applicant been terminated from or convicted of a crime related to a federal or state program?

☐ **Yes** ☐ **No**

If yes, please explain:

SECTION VIII — CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS

Copy this page and complete as needed.

Does the applicant have a controlling interest in any vendors of special service categories such as, but not limited to, drugs/pharmacy, medical supplies/durable medical equipment, transportation, visiting nurse and/or home health agency, providers of any type of therapy?

☐ **Yes.** Identify each health care provider the applicant has a controlling interest or ownership in, supply the information, and describe the type and percentage of controlling interest or ownership (e.g., 5% owner, 50% partner, administrator).
☐ **No.** Go to Section IX.

Name			
Medical Provider Number(s)	SSN/EIN		
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	

Are all of the services provided by the applicant and any special service vendors in which the applicant has a controlling interest billed under a single provider number?

☐ **Yes.** Enter the number:_____.
☐ **No.**

SECTION IX — CONTROLLING INTEREST OTHERS (INDIVIDUAL AND / OR ENTITY) HAVE IN THE APPLICANT

Copy this page and complete as needed.

Does any person and/or entity have a controlling interest in any of the Medicaid services the applicant provides? ☐ **Yes** ☐ **No**

If yes, list the names and addresses of all persons and/or entities with a controlling interest in the applicant.

Name — Individual or Entity			
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	
SSN or IRS Tax Number	Provider Number, if applicable		

SCHOOL-BASED SERVICES BENEFIT

The Medicaid School-Based Services (SBS) Benefit allows either your school district or Cooperative Education Service Agency (CESA) or County Children with Disabilities Education Board (CCDEB) to bill Medicaid for services covered under the SBS benefit. School districts may be Medicaid certified under the umbrella certification of a CESA or be separately certified as a school district, but not both.

School districts have the option of various arrangements for certification and billing. However, in all of the cases described below, the certified agency, whether it be the school district or CESA or CCDEB, is legally responsible for all claims submitted under their Medicaid provider number.

1. School district SBS applicant can choose itself as payee and do their own billing.
2. School district SBS applicant can choose itself as payee and have CESA, CCDEB, or a billing agent do their billing.
3. School district SBS applicant can choose CESA or CCDEB as payee and have CESA, CCDEB, or a billing agent do their billing.
4. School district can choose to not apply separately and instead be listed under the CESA's application.
5. School district can choose to not apply separately and instead have their CCDEB bill for services provided by the CCDEB and the school district.
6. CCDEB SBS applicant can choose itself as payee and do their own billing.
7. CCDEB SBS applicant can choose itself as payee and have a billing agent do their own billing.

School districts cannot obtain SBS certification for some SBS services (i.e., physical and occupational therapy) and be listed on a CESA's application for other SBS services (i.e., speech therapy and nursing).

School districts, CESAs and CCDEBs can **only** be certified as SBS providers. They cannot be certified separately as therapy, mental health, or any other type of provider. Therefore, on page 3, Section 4 of the "*Wisconsin Medicaid Provider Application*," **check only "School-Based Services**" as the type of certification.

SCHOOL-BASED SERVICES (SBS) BENEFIT

SPECIFIC COVERED SERVICES, PROVIDER QUALIFICATIONS, AND PRESCRIPTION REQUIREMENTS

Speech, Language, Audiology and Hearing
Covered SBS Individualized Education Program/Individualized Family Service Program (IEP/IFSP) speech, language, hearing and audiological services are for individuals with speech, language, or hearing disorders that adversely affect the individual's functioning**.** ***Services include:*** ✓ Evaluation and testing to determine the individual's need for these services and recommendations for a course of treatment; and treatment. ✓ Individual or group therapy or treatment in groups of 2 to 7 individuals. ✓ Medical equipment identified in the IEP or IFSP intended for only one child for use at school *and* home.
Provider qualifications: These services are performed by or under the direction of a Department of Public Instruction (DPI) certified speech pathologist or by an audiologist.
Prescription requirements: These services must have a physician referral or the school district/Cooperative Educational Service Agency (CESA)/County Children with Disabilities Education Board (CCDEB) must have a "Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the SBS Benefit" form on file. The services must be identified in an IEP or IFSP for coverage by Wisconsin Medicaid**.**
Occupational Therapy
Covered SBS IEP/IFSP occupational therapy services are to identify, treat, rehabilitate, restore, improve or compensate for medical problems that interfere with age appropriate functional performance**.** ***Services include:*** ✓ Evaluation and reevaluation; recommendations for a course of treatment; rehabilitative, active, or restorative treatment services. ✓ Individual or group therapy or treatment in groups of 2 to 7 individuals. ✓ Medical equipment identified in the IEP or IFSP intended for only one child for use at school *and* home.
Provider qualifications: These services are performed by or under the direction of a DPI-certified occupational therapist.
Prescription requirements: These services must be prescribed by a physician and identified in an IEP or IFSP for coverage by Wisconsin Medicaid or the school district/CESA/CCDEB must have a "Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the SBS Benefit" form on file.

Physical Therapy

Covered SBS IEP/IFSP physical therapy services identify, treat, rehabilitate, restore, improve or compensate for medical problems.

Services include:

- ✓ Evaluations to determine an individual's need for physical therapy; recommendations for a course of treatment; and therapeutic exercises and rehabilitative procedures.
- ✓ Individual or group therapy or treatment in groups of 2 to 7 individuals.
- ✓ medical equipment identified in the IEP or IFSP intended for only one child for use at school *and* home.

Provider qualifications:
These services are performed by or under the direction of a DPI-certified physical therapist.

Prescription requirements:
These services must be prescribed by a physician and be identified in an IEP or IFSP for coverage by Wisconsin Medicaid. If the school district/CESA/CCDEB has a "Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the SBS Benefit" form on file, a prescription is only required under limited circumstances as required by DR&L.

Nursing

Covered SBS IEP/IFSP professional nursing services relevant to the recipient's medical needs.

Services include, but are not limited to:

- ✓ evaluation and management services, including screens and referrals for health needs; treatment and other measures; and medication management.

Provider qualifications:
These services are performed by a registered nurse, licensed practical nurse, or are delegated under nursing protocols.

Prescription requirements:
These services are prescribed or recommended by a physician or advance practice nurse with prescribing authority, and must be identified in an IEP or IFSP for coverage by Wisconsin Medicaid. If the school district/CESA/CCDEB has a "Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the SBS Benefit" form on file, an initial prescription or referral by a physician or advanced practice nurse with prescribing authority is required, along with any necessary subsequent prescriptions.

Psychological, Counseling and Social Work

Covered SBS IEP/IFSP psychological, counseling, and social work services include diagnostic or active treatments with the intent to reasonably improve the recipient's physical or mental condition.

Services include:

- ✓ IEP/IFSP diagnostic testing and evaluation that appraises cognitive, emotional, and social functioning and self-concept; therapy and treatment that plans, manages, and provides a program, or psychological, counseling or social work services to individuals with psychological or behavioral problems; and crisis intervention.
- ✓ treatment, psychological counseling and social work services to individuals or groups of 2-10 individuals.

Provider qualifications:
These services are performed by a DPI-certified school psychologist, school counselor, or school social work staff.

Prescription requirements:
These services are prescribed or referred by a physician or licensed Ph.D. psychologist or the school district/CESA/CCDEB must have a "Request for a Waiver to Wisconsin Medicaid Prescription Requirements Under the SBS Benefit" form on file. The services must be identified in an IEP or IFSP for coverage by Wisconsin Medicaid.

Other Developmental Testing and Assessments

Covered SBS IEP/IFSP testing and assessments performed by therapists, psychologists, social workers, counselors and nurses are included in the SBS covered services for their respective professional areas, as described in the specific service categories. Wisconsin Medicaid also covers SBS IEP/IFSP developmental testing and assessments performed by other school staff, as described below:

Services include:

- ✓ evaluations, tests and related activities performed to determine if motor, speech, language, or psychological problems exist, or to detect developmental lags in the determination of eligibility under IDEA and result in an IEP/IFSP.

Provider qualifications:
These services are performed by a licensed physician or psychiatrist, director of special education and/or pupil services, special education teacher, diagnostic teacher, or other certified school staff.

Prescription requirements:
Testing and assessments are covered only when an IEP/IFSP results from the tests and assessments; a separate prescription or referral is not required.

Transportation
Covered transportation services are provided to individuals who require special transportation accommodations in vehicles equipped with a ramp or lift, any vehicle with an aide required to assist the child, or standard school bus transportation if the child resides in an area that does not have school bus transportation; where the need for special transport is identified as a needed service in the child's IEP or IFSP; and the child will receive a Wisconsin Medicaid-covered service on the day transportation is provided. ***Services include:*** ✓ Transportation from the child's home to and from school on the same day an SBS service is provided in the school. ✓ Transportation from school to a service site and back to school or home if the SBS service is provided at a non-school location, such as a hospital.
Provider qualifications: These services are performed by a school or contracted provider.
Prescription requirements: No prescription for transportation is required. The service must be included in the IEP or IFSP. The covered service that the child is transported to must meet Wisconsin Medicaid's requirements for that service.

OPTIONAL SCHOOL BASED SERVICES ACTIVITY LOG

1. Month/Year					3. Student's Name (Last, First, Middle)	
2. School's Name					4. Student' Birth Date (MM/DD/YY)	
5. Date of Service			6. General Service Category	7. Unit of Service (time, quantity, miles)	8. Group or Individual	9. Describe Specific Services Delivered and Describe Student's Response/Progress (response/progress not required for transportation)
MM	DD	YY				
10. Describe Communication with Non-School Wisconsin Medicaid Providers:						
11. Clinician/Staff Signature:						

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider. claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services.

SCHOOL BASED SERVICES
CHART A

SCHOOL DISTRICTS INCLUDED UNDER THIS CESA's SBS APPLICATION

INSTRUCTIONS: CESAs only complete this form to identify school districts included under this CESA's Medicaid certification for SBS. The instruction numbers correspond to the numbered sections on the chart.

1. Identify the CESA.
2. List all school districts included under this CESA's Medicaid SBS certification application.
3. List the Tax I.D. Number belonging to each school district listed for #2.
4. Sign and date the form.

Please make a copy and attach additional pages if necessary. Resubmit this form whenever the list of school districts included under this CESA's certification changes.

1. CESA #_____

CHART A	
2. SCHOOL DISTRICT NAME	**3. TAX I.D. NUMBER**

4. _____ _____
Original Signature of School District or CESA Administrator (or Authorized Agent or Designee) **Date**

SCHOOL BASED SERVICES
CHART B

DUPLICATE GROUP/CLINIC/AGENCY MEDICAID PROVIDER CERTIFICATION

INSTRUCTIONS: The instruction numbers correspond to the numbered sections on the chart.

1. List all group/clinic/agency provider numbers held by schools, school districts, CESAs and CCDEBs included in this application for the duplicate provider certification types listed in the left column. **Enter N/A if not applicable.**
2. Sign and date the form.

Please make a copy and attach additional pages, if necessary.

CHART B - GROUP/CLINIC/AGENCY PROVIDER NUMBERS	
DUPLICATE PROVIDER CERTIFICATION TYPES	**1. CURRENT MEDICAID CERTIFICATION PROVIDER NUMBER(S)**
Physical Therapy Group	
Occupational Therapy Group	
Speech and Hearing Clinic	
Audiology Group	
Speech Pathology/Therapy Group	
Therapy Group	
Rehabilitation Agency	
Transportation	
Nurse Practitioner Group Nurse Group	

2. _____ _____
Original Signature of School District or CESA/CCDEB Administrator (or Authorized Agent or Designee) **Date**

SCHOOL BASED SERVICES
CHART C

DUPLICATE INDIVIDUAL MEDICAID PROVIDER CERTIFICATION

INSTRUCTIONS: The instruction numbers correspond to the numbered sections on the chart.

1. List all current Medicaid provider numbers for individuals with the duplicate provider certification types listed in the left column. **Enter N/A if not applicable.**

2. In the column labeled "Check Choice," place a checkmark next to the individual's current Medicaid certification provider number to indicate either "change payee" or "end certification," based on the preference of the individual provider.

   a. Change Payee: If checked, the individual provider must complete a Medicaid provider change of address or status form to reassign their payee name, address and Tax I.D. number. Attach completed Medicaid provider change of address or status form to this chart to send to Wisconsin Medicaid with the SBS application.

   b. End Certification: If the individual provider does not chose to change their payee, Wisconsin Medicaid will send notice to the individual that his/her certification will be canceled if a Medicaid provider change of address or status form is not received by the date specified in the notice.

3. Sign and date the form.

Please make a copy and attach additional pages if necessary.

INDIVIDUAL PROVIDERS' NUMBERS			
DUPLICATE PROVIDER CERTIFICATION TYPES	**1. CURRENT MEDICAID CERTIFICATION PROVIDER NUMBER(S)**	**2. CHECK CHOICE**	
		CHANGE PAYEE	**END CERTIFICATION**
Physical Therapists and Assistants			
Occupational Therapists and Assistants			

SCHOOL BASED SERVICES
CHART C

INDIVIDUAL PROVIDERS' NUMBERS			
DUPLICATE PROVIDER CERTIFICATION TYPES	**1. CURRENT MEDICAID CERTIFICATION PROVIDER NUMBER(S)**	**2. CHECK CHOICE**	
		CHANGE PAYEE	**END CERTIFICATION**
Audiologist			
Speech Pathologists			
Nurse Practitioners			
Nurses (Individually Certified RNs or LPNs)			

3. _____ _____
Original Signature of School District or CESA/CCDEB Administrator (or Authorized Agent or Designee) **Date**

SCHOOL BASED SERVICES
CHART D

NON-DUPLICATE MEDICAID PROVIDER CERTIFICATION

INSTRUCTIONS: The instruction numbers correspond to the numbered sections on the chart.

1. **Identify the non-duplicate provider certification only where the school, school district, CESA or CCDEB is the payee.** The school, school district, CESA or CCDEB is the payee when the Medicaid payment is made payable to the school, school district, CESA or CCDEB and the Medicaid income is reported to the school's, school district's, CESA's or CCDEB's Tax I.D. Number. Medicaid will NOT cancel or change non-duplicate provider certification. THIS IS COLLECTED FOR INFORMATIONAL PURPOSES ONLY. **Enter N/A if not applicable.**
2. Sign and date the form regardless of whether you have non-duplicate provider numbers listed.

Please make a copy and attach additional pages if necessary.

CHART D	
NON-DUPLICATE PROVIDER CERTIFICATION TYPES	**1. CURRENT MEDICAID CERTIFICATION PROVIDER NUMBER(S):**
Prenatal Care Coordination	
Personal Care Provider	
Case Management	
HealthCheck	
Durable Medical Equipment Vendor	
Other_____	

2. _____ _____
Original Signature of School District or CESA/CCDEB Administrator (or Authorized Agent or Designee) **Date**

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider.

Request for a Waiver to Wisconsin Medicaid Prescription Requirements under the SBS Benefit to Conform to DPI Requirements

(HFS 106.13, Wis. Admin. Code)

Provider Name _____ **Provider Number** _____

requests a waiver under HFS 106.13, Wis. Admin. Code, for the requirement for obtaining prescriptions under the school-based services (SBS) benefit following HFS 105.53(2) and 107.36(1) and (2), Wis. Admin. Code.

Under this waiver, our school district or CESA must do all of the following:

- Continue to meet the Department of Public Instruction and Department of Regulation and Licensing standards for prescriptions for services provided to children in the school setting under the SBS benefit.
- Notify the child's HMO, physician, physician specialist, physician assistant, or nurse practitioner regarding the services the child obtains under the SBS benefit at least annually. This activity must be documented in the child's record.
- When a child receives similar services from other Medicaid providers, documented communication must occur at least annually. The communication must be documented in the recipient's records and copies of the child's Individualized Education Program must be supplied to other providers when requested.
- Coordinate care with managed care organizations through Memorandums of Understanding as currently required under the SBS benefit. (See Section II-D of Part X, the SBS handbook, for more information.)

We request this waiver from the Wisconsin Division of Health Care Financing, for services provided on and after January 1, 1998, until this requirement is eliminated through a Wisconsin Administrative Code change. Thank you.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider.

Name: _____

Title: _____

Date: _____

_____ _____

Signature Date

MA03118.KZ/CERT

Effective date: January 1, 1998
Revised: May 2001

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

DOH 1111H (4/00)
DHFS/Health
Wis. Adm. Code HFS 105.01

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT
(For School-Based Services)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with (fill in name here)

_____,
Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents.

a Provider of school-based services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and Bulletins, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Social Services Standards for Equal Opportunity in Service Delivery, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. The Provider shall be liable for the entire amount of any overpayment, as defined by Medicaid program policies and procedures.

4. The Provider shall also be liable for the entire amount of an audit adjustment and/or disallowance attributed to the Provider by the Federal Government or by the Department. No fiscal sanction shall, under this paragraph, be taken against a Provider unless it is based upon a specific policy which was: (a) effective during the time period that is being audited; and (b) communicated to the Provider in writing by the Department or the Federal Government prior to the time period audited.

5. The Provider shall assure and document the availability and use of non-federal funds sufficient to provide for the non-federal share of all Wisconsin Medicaid program payments under this agreement.

6. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid program.

7. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. The Provider shall furnish to the Department in writing:

   (a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other Providers in which it has a controlling interest or ownership;

   (b) the names and addresses of all persons who have a controlling interest in the Provider;

   (c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

   (d) the names, addresses, and any significant business transactions between the Provider and any subcontractor; and

   (e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

8. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses, certification, or similar entitlements as specified in HFS PI 3, Wisconsin Administrative Code, or s. 441.06 or s. 441.10 Wisconsin Stats., and required by federal, regulations for the provision of the service.

9. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Provider to the Wisconsin Medicaid program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

10. Unless earlier terminated as provided in paragraph 11 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

11. This agreement may be terminated as follows:

   (a) By the Provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

   (b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

Signatures follow on Page 3

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services.

ALL THREE PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER

Name of Provider (Typed or Printed)

Address

City (WI only) Zip

*Typed or Printed Name of School District or CESA Administrator

TITLE: _____

BY: _____
*Signature of Provider (School District or CESA Administrator)

DATE: _____ PHONE #: _____

(For Department Use Only)

STATE OF WISCONSIN
DEPARTMENT OF HEALTH
AND FAMILY SERVICES

BY: _____

DATE: _____

* Authorized Agent or Designee is Acceptable.

NOTE: The Provider Agreement for each School-Based Services Provider must include the signature of the Authorized Agent or Designee of the School District or CESA providing the matching funds below, signifying approval for the use of non-federal funds as the matching funds.

By my signature, I certify that our School District or CESA provides the matching funds for all school-based services billed by our school district or CESA:

Signature of Authorized Agent or Designee of School District or CESA

Typed/Printed Name of Authorized Agent or Designee

Name of School District or CESA Providing Matching Funds

Address City (WI only) Zip

DATE: _____ PHONE #: _____

THE DEPARTMENT CANNOT AND WILL NOT AGREE TO MODIFICATIONS TO THIS AGREEMENT. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

Print clearly, this is your mailing label. For recertification (renewals) only. Please fill in the address below **if** the countersigned agreement should be sent to a **different** address than the top section above.

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DOH 1111H (4/00)
DHFS/Health
Wis. Adm. Code HFS 105.01

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT
(For School-Based Services)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with (fill in name here)

_____,
Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents.

a Provider of school-based services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and Bulletins, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Social Services Standards for Equal Opportunity in Service Delivery, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. The Provider shall be liable for the entire amount of any overpayment, as defined by Medicaid program policies and procedures.

4. The Provider shall also be liable for the entire amount of an audit adjustment and/or disallowance attributed to the Provider by the Federal Government or by the Department. No fiscal sanction shall, under this paragraph, be taken against a Provider unless it is based upon a specific policy which was: (a) effective during the time period that is being audited; and (b) communicated to the Provider in writing by the Department or the Federal Government prior to the time period audited.

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6. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid program.

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   (a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other Providers in which it has a controlling interest or ownership;

   (b) the names and addresses of all persons who have a controlling interest in the Provider;

   (c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

   (d) the names, addresses, and any significant business transactions between the Provider and any subcontractor; and

   (e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

8. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses, certification, or similar entitlements as specified in HFS PI 3, Wisconsin Administrative Code, or s. 441.06 or s. 441.10 Wisconsin Stats., and required by federal, regulations for the provision of the service.

9. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Provider to the Wisconsin Medicaid program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

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Signatures follow on Page 3

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ALL THREE PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER

Name of Provider (Typed or Printed)

Address

City (WI only) Zip

*Typed or Printed Name of School District or CESA Administrator

TITLE: _____

BY: _____
*Signature of Provider (School District or CESA Administrator)

DATE: _____ PHONE #: _____

(For Department Use Only)

STATE OF WISCONSIN
DEPARTMENT OF HEALTH
AND FAMILY SERVICES

BY: _____

DATE: _____

* Authorized Agent or Designee is Acceptable.

NOTE: The Provider Agreement for each School-Based Services Provider must include the signature of the Authorized Agent or Designee of the School District or CESA providing the matching funds below, signifying approval for the use of non-federal funds as the matching funds.

By my signature, I certify that our School District or CESA provides the matching funds for all school-based services billed by our school district or CESA:

Signature of Authorized Agent or Designee of School District or CESA

Typed/Printed Name of Authorized Agent or Designee

Name of School District or CESA Providing Matching Funds

Address City (WI only) Zip

DATE: _____ PHONE #: _____

THE DEPARTMENT CANNOT AND WILL NOT AGREE TO MODIFICATIONS TO THIS AGREEMENT. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

Print clearly, this is your mailing label. For recertification (renewals) only. Please fill in the address below **if** the countersigned agreement should be sent to a **different** address than the top section above.

WISCONSIN MEDICAID
ELECTRONIC BILLING GENERAL INFORMATION

Wisconsin Medicaid has several electronic billing options available for trading partners to submit electronic claims. HIPAA compliant Software is available at no cost for submitting claims to Wisconsin Medicaid except for retail pharmacy services. For further information, or to order free software refer to: *dhfs.wisconsin.gov/medicaid9/pes/pes.htm* or contact the Provider Services at 1-800-947-9627 or the EDI Department at 608-221-9036.

ELECTRONIC METHODS FOR SUBMITTING MEDICAID CLAIMS

- Provider Electronic Solutions (PES) – Wisconsin Medicaid HIPAA Compliant Free Software
    - 837 Institutional
    - 837 Professional
    - 837 Dental
    - 997 Functional Acknowledgement
    - 835 Health Care Payment Advice

- Cartridge - Providers with the capability to create their claim information on 3480, 3490 or 3490E cartridge can submit those tapes to Wisconsin Medicaid in the HIPAA compliant formats.

- RAS/Internet – Allows providers to send their data files to Wisconsin Medicaid using a direct RAS connection or Web Browser.

- Third Party Biller – Providers have the option of purchasing a billing system or contracting with a Third Party Biller, to submit their claims.